THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-2111.M5

MDR Tracking Number: M5-04-2182-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on March 17, 2004.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with § 133.308(r)(9), the Commission hereby Orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the Order, the Commission will add 20-days to the date the Order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. The hot/cold packs, electrical stimulation, ultrasound, neuromuscular re-education, office visits, and physician team conference rendered on 3/18/03 through 5/23/03 were found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On June 24, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Rationale
3/18/03	99213	$75.00	$0.00	No EOB	$48.00	Review of the requestors and respondents documentation revealed that neither party submitted copies of EOBs, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed service or services will be reviewed according to the 1996 Medical Fee Guideline. The requestor submitted relevant information to support delivery of service. Reimbursement is recommended in the amount of $240.00.
3/19/03	99213	$75.00	$0.00	No EOB	$48.00	
3/20/03	99213	$75.00	$0.00	No EOB	$48.00	
3/25/03	99213	$75.00	$0.00	No EOB	$48.00	
4/1/03	99213	$75.00	$0.00	No EOB	$48.00	
TOTAL		$375.00	$0.00		$240.00	

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service 3/18/03 through 5/23/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 8th day of October 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

June 3, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-2182-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
------ Case #:

------ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ------ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ------ for independent review in accordance with this Rule.

------ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ------ external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ------ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or

providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ------ for independent review. In addition, the ------ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 37 year-old female who sustained a work related injury on ------. On 6/25/02 the patient was evaluated by an orthopedic surgeon with the diagnoses of disc protrusion of the L5-S1 level. The patient was referred for physical therapy but did not begin therapy until 2/11/03. The patient was reported to have undergone epidural steroid injections and treatment with an EMS unit for pain control. Physical therapy treatment consisted of hot/cold packs, ultrasound, electrical stimulation, and neuromuscular reeducation.

Requested Services

Hot/cold pack therapy, ultrasound, electrical stimulation, neuromuscular reeducation, level III office visits, and physician team conference from 3/18/03 through 5/23/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Letter 5/13/04
2. Orthopedic notes 6/25/02 – 6/24/03
3. SOAP notes 3/16/03 – 4/16/03

Documents Submitted by Respondent:

1. No documents submitted

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The ------ chiropractor reviewer noted that this case concerns a 37 year-old female who sustained a work related injury to her back on ------. The ------ chiropractor reviewer also noted that the diagnoses for this patient included disc protrusion of the L5-S1 level. The ------ chiropractor reviewer indicated that the patient had a L5-S1 disc herniation that coincided with her pain pattern. The ------ chiropractor reviewer also indicated that the patient had not received any beneficial care for this injury prior to 2/03. The ------ chiropractor reviewer explained that a 6-8 week trial of conservative treatment is the standard of care for this type of injury. The ------ chiropractor reviewer also explained that if the patient does not respond to the trial of conservative care, the patient is routinely referred out for further treatment options, such as epidural steroid injections or possible surgical intervention. The ------ chiropractor reviewer further explained that interaction between all providers involved is medically necessary to ensure the patient is receiving proper treatment. Therefore, the ------ chiropractor consultant

concluded that the hot/cold pack therapy, ultrasound, electrical stimulation, neuromuscular reeducation, level III office visits, and physician team conference from 3/18/03 through 5/23/03 were medically necessary to treat this patient's condition.

Sincerely,